

Instructions

Please respond to every question unless directed to do otherwise. When you have completed the application, submit **3 copies** of the completed application* to the Office of Health Systems Development, Rhode Island Department of Health, 3 Capitol Hill, Room 407, Providence, Rhode Island 02908. Upon submission, the application will be reviewed for acceptability, and the applicant will be notified of any deficiencies if the application has been found not acceptable in form. Applications found substantially deficient may not be reviewed. Thus, a complete response to every question in this application and its relevant appendices may save valuable time.

Completion and submission of this application is a prerequisite to licensure when there is a change in ownership, operator or lessee of an existing health care facility. This application should be completed after a thorough review of Title 23, Chapter 17 of the General Laws of Rhode Island, as amended, and the Rules and Regulations for licensing of health care facilities.

Several questions in this application form and its appendices require the use of additional sheets of paper. On separate sheets of paper, please identify the application form questions to which they apply, and please attach the separate sheets of paper either to the page in the application form on which the question appears or at the end of the application under an individual tab. Each separate answer sheet to a question should be numbered with the number of the question from the application plus a consecutive lower case letter, if there is more than one sheet. Please indicate 'N/A' next to any question that does not pertain to your proposal. Included with this application are several appendices. Please complete those appendices which are applicable to your proposal and include them with the application.

The application must be accompanied by an appropriate fee, instructions for which are identified on the cover page of the application. Application fees for applications accepted for review shall be non-refundable. Should your application be deemed unacceptable for review, the check for the application fee will be returned. The application must be submitted in a softbound format to facilitate the mailing of the application to the Health Services Council.

Once the application is deemed acceptable for review, **18 copies** of the completed application including all the satisfied deficient materials must be submitted to the Office of Health Systems Development prior to the date of review initiation.

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

*Applicants need not copy this page nor appendices not applicable to this proposal.

Change in Effective Control Application

(April 2005)

Name of Applicant: _____

Name of Facility: _____

Date Application Submitted: _____

Amount of Fee: _____

Include a fee in the form of a check made out to the "General Treasurer of Rhode Island" in the amount equal to two tenths of one percent (0.2%) of the projected annual facility net operating revenue contained in the application; provided, however, that the minimum application fee shall be fifteen hundred dollars (\$1,500) and the maximum application fee shall not exceed twenty thousand dollars (\$20,000). Initially, please provide **3 completed applications** to the address identified at the bottom of this page. Once the application is deemed acceptable for review, **18 copies** of the completed application including all the satisfied deficient materials must be submitted to the Office of Health Systems Development prior to the date of review initiation.

All questions concerning this application should be directed to the Office of Health Systems Development at
(401) 222-2788

Please have the appropriate individual attest to the following:

"I hereby certify that the information contained in this application is complete, accurate and true."

signed and dated by the President or Chief Executive Officer

signed and dated by Notary Public

Change in Effective Control Application

1. Please provide an executive summary describing the nature and scope of the proposal (USE ADDITIONAL PAGES IF NECESSARY):

2. Legal name, FEIN # or Social Security #, and address of the applicant (i.e., the proposed licensee):

3. Name, title, address, phone, fax and e-mail for the applicant's President or CEO:

4. Name, title, address, phone, fax and e-mail of one contact person for this application process (only if different from the President/CEO in Question 3):

5. A. **EXISTING ENTITY**: LICENSE CATEGORY (E. G. HOSPITAL): _____

NAME OF FACILITY: _____ LIC. NO: _____

ADDRESS: _____ TEL. NO: _____

TYPE OF OWNERSHIP: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION

☐ LIMITED LIABILITY CORPORATION

TAX STATUS: ☐ FOR PROFIT ☐ NON-PROFIT

B. **PROPOSED ENTITY**:

NAME OF FACILITY: _____

ADDRESS: _____

TYPE OF OWNERSHIP: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION

☐ LIMITED LIABILITY CORPORATION

TAX STATUS: ☐ FOR PROFIT ☐ NON-PROFIT

Change in Effective Control Application

6. Does this proposal involve a nursing facility? Yes ___ No___

- If response to Question 6 is 'Yes', please complete Appendix C.

7. Will the facility be operated under management agreement with an outside party? Yes___ No ___

- If response to Question 7 is "Yes", please provide copies of that agreement.

8. Will the proposal involve the facility/ies providing healthcare services under contract with an outside party? Yes___ No ___

- If response to Question 8 is "Yes", please identify and describe those services to be contracted out.

9. Estimate the date (month and year) for the proposed transfer of ownership, if approved:

10. Please provide a concise description of the services currently offered by the licensed entity and identify any services that will be added, terminated, expanded, or reduced and state the reasons therefore (USE ADDITIONAL PAGES IF NECESSARY):

11. Please identify the long-term plans of the applicant with respect to the health care programs and health care services to be provided at the facility:

12. Does the entity seeking licensure plan to participate in Medicare or Medicaid (Titles XVIII or XIX of the Social Security Act)?

MEDICARE: Yes___ No___ MEDICAID: Yes___ No___

- If response to Question 11 for either Medicare and/or Medicaid is 'No', please explain.

13. Please provide all appropriate signed legal transfer documents (i.e. purchase and sale agreement, affiliation agreement); **NOTE:** these documents must cause both parties to be legally bound.

14. List all officers, members of the board of directors, trustees, stockholders, partners, and other individuals who have an equity or otherwise controlling interest in the applicant. For each individual, provide their home and business address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

Change in Effective Control Application

15. For each individual listed in response to Question 14, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. JACHO, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency.

16. If any individual listed in response to Question 14, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

17. Have any individuals listed in response to Question 14 been convicted of any state or federal criminal violation within the past 20 years? Yes___ No___.

- If response to Question 17 is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

18. Please provide organization charts of both agencies (existing entity and the applicant) for prior to transfer and post transfer, identifying all "parent" legal entities with direct or indirect ownership in or control, all "sister" legal entities also owned or controlled by the parent(s), and all "subsidiary" legal entities.

19. For all entities identified in response to Question 18, please provide a brief narrative clearly explaining the relationship of these entities to each other, including ownership.

20. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 18. For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. JACHO, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency.

21. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 18 during the last 5-years had bankruptcies and/or were placed in receiverships? Yes___ No___

- If response to Question 21 is 'Yes', please identify the facility and its current status.

22. If the proposed owner, operator or director owned, operated or directed a health care facility (both within and outside Rhode Island) within the past five years, please demonstrate the record of that person(s) with respect to access of traditionally underserved populations to its health care facilities.

23. Please identify the proposed immediate and long-term plans of the applicant to ensure adequate and appropriate access to the program and health care services to be provided by the health care facility/ies to traditionally underserved populations.

24. After the proposed change in effective control, will the facility/ies provide medically necessary services to patients without discrimination, including the patients' ability to pay for services? Yes___ No___.

- If response to Question 24 is 'No', please explain.

25. Please provide a copy of the Quality Assurance Policies (for the services) and a detailed explanation of how quality assurance for patient services will be implemented at the facility/ies by the applicant.

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26. Please provide a detailed description about the amount and source of the equity and debt commitment for this transaction. (**NOTE:** If debt is contemplated as part of the financing, please complete Appendix E). Additionally, please demonstrate the following:

- A. The immediate and long-term financial feasibility of the proposed financing plan;
- B. The relative availability of funds for capital and operating needs; and
- C. The applicant's financial capability.

27. Please provide legally binding evidence of site control (e.g., deed, lease, option, etc.) sufficient to enable the applicant to have use and possession of the subject property, if applicable.

28. If the facility is not-for-profit and/or affiliated with a not-for-profit, please provide written approval from the Rhode Island Department of Attorney General of the proposal.

29. Please provide each of the following documents applicable to the applicant's legal status:

- Certificate and Articles of Incorporation and By-Laws (for corporations)
- Certificate of Partnership and Partnership Agreement (for partnerships)
- Certificate of Organization and Operating Agreement (for limited liability corporations)
- If any of the above documents are proposed to be revised or modified in any way as a result of the implementation of the proposed change in effective control, please provide the present documents and the proposed documents and **clearly identify** the revisions and modifications.

30. If the applicant and/or one of its parent companies (or ultimate parent) is a publicly traded corporation, please provide copies of its most recent SEC 10K filing.

31. Please provide audited financial statements (which should include an income statement, balance sheet and cash flow statement) for the last three years for the applicant, and/or its ultimate parent, and for the existing facility.

32. All applicants must complete Appendix A, D and F.

APPENDIX A

All applicants must complete this Appendix.

1. Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20 percent equity investment in CEC projects.

Source	Amount	Percent	Interest Rate	Terms (Yrs.)
Equity*	\$	%		
Debt**	\$	%	%	
Lease	\$	%	%	
TOTAL	\$	100%		

* Equity means non-debt funds contributed towards the capital cost related to a change in owner or change in operator of a healthcare facility which funds are free and clear of any repayment or liens against the assets of the proposed owner and/or licensee and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged.

** If debt financing is indicated, please complete Appendix E.

2. Please identify the total number of FTEs (full time equivalents) and the associated payroll expense (with fringe benefits) required to staff this proposal in the last full year and as projected in the first full year after the implementation of the proposal.

	CURRENT YEAR 20__		<-- FIRST FULL OPERATING YEAR 20__ -->			
PERSONELL	EXISTING		ADDITIONS/(REDUCTIONS)		NEW TOTALS	
	Number of FTEs	Payroll W/Fringes	Number of FTEs	Payroll W/Fringes	Number of FTEs	Payroll W/Fringes
Medical Director		\$		\$		\$
Physicians		\$		\$		\$
Administrator		\$		\$		\$
RNs		\$		\$		\$
LPNs		\$		\$		\$
Nursing Aides		\$		\$		\$
PTs		\$		\$		\$
Ots		\$		\$		\$
Speech Therapists		\$		\$		\$
Clerical		\$		\$		\$
Housekeeping		\$		\$		\$
Other:()		\$		\$		\$
()		\$		\$		\$
()		\$		\$		\$
()		\$		\$		\$
TOTALS		\$		\$		\$

APPENDIX A (CONT.)

3. Please complete the following table for the facility for the last full year, the current year and for the first year after the implementation of the proposal. Round all amounts to the nearest dollar.

	ACTUAL PREVIOUS YEAR 20__	BUDGETED CURRENT YEAR 20__	<-- FIRST FULL OPERATING YEAR 20__ -->		
			CEC DENIED	CEC APPROVED	INCREMENTAL DIFFERENCE
REVENUES:					
Net Patient Revenue	\$	\$	\$	\$	\$
Other: ()	\$	\$	\$	\$	\$
Total Revenue	\$	\$	\$	\$	\$
EXPENSES:	\$	\$	\$	\$	\$
Payroll w/Fringes	\$	\$	\$	\$	\$
Bad Debt	\$	\$	\$	\$	\$
Supplies	\$	\$	\$	\$	\$
Office Expenses	\$	\$	\$	\$	\$
Utilities	\$	\$	\$	\$	\$
Insurance	\$	\$	\$	\$	\$
Interest	\$	\$	\$	\$	\$
Depreciation/Amortization	\$	\$	\$	\$	\$
Leasehold Expenses	\$	\$	\$	\$	\$
Other: ()	\$	\$	\$	\$	\$
Other: ()	\$	\$	\$	\$	\$
Total Expenses	\$	\$	\$	\$	\$
OPERATING PROFIT:	\$	\$	\$	\$	\$

4. Please provide utilization statistics (both as a dollar value and percentage) for the existing facility by completing the table below for the requested years.

	ACTUAL (PAST 3 YEARS)						BUDGETED CURRENT FY 20__		PROJECTED (IF CEC APPROVED)					
PAYOR SOURCE:	FY 20__		FY 20__		FY 20__				FY 20__		FY 20__		FY 20__	
Medicare	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Medicaid	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Blue Cross	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Commercial	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
HMO's	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Self Pay	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Other: (_____)	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Charity Care	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
TOTAL:	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%

APPENDIX B

RHODE ISLAND STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS DEVELOPMENT

Compliance Report

(Name of Applicant)_____ has applied for licensure as a healthcare facility in Rhode Island. As part of the regulatory requirements to determine the character, competence and other quality related information of the applicant, the Office of Health Systems Development is requesting the following information regarding the health care facilities operated by or affiliated with the applicant, as listed on the attached sheet.

Please answer the following questions.

1. Are the agencies/facilities currently licensed and in substantial compliance with all applicable codes, rules and regulations? Yes___ No___

If the answer to #1 is "NO", please identify the facility(ies) and briefly explain the licensure status.

2. Has there been any enforcement actions against these agencies/facilities in the past five years? Yes___ No___

If the answer to #2 is "YES", please identify the facility(ies) and include any information relevant to those enforcement actions (reason for action, stipulation, fine, etc.). In addition, please furnish a brief description of the outcome of the most recent survey, including any deficiencies cited. Additional pages may be attached, if needed.

Reviewer's Name: _____ Title: _____

Department: _____ State: _____

Telephone _____ E-mail _____

Reviewer's Signature: _____ Date: _____

If you have any questions, please contact Michael Dexter at (401) 222-2788 or e-mail, MikeD@health.ri.gov
Please return the completed form within 15 days to the address below:

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 407
Providence, Rhode Island 02908

Thank you.

Attachment

APPENDIX B (CONT.)

Applicant, please provide the following information identifying each facility to the appropriate state agency as an attachment to the letter in the table below, use additional pages if necessary. Please make sure to identify yourself in the cover letter by filling in the blank for 'Name of Applicant'.

[illegible]

APPENDIX C**NURSING HOME PROPOSALS**

All change in effective control applications, which involve nursing homes, must be accompanied by responses to the questions posed herein.

1. Please provide the current patient census at the facility by payor source in the table below.

Date of Census __/__/__, Licensed bed capacity _____

Payor Source	Number of Patients	Percent of Total
Medicaid	#	%
Medicare	#	%
Commercial	#	%
Private Pay	#	%
Veterans	#	%
Other: ()	#	%
TOTAL:	#	100%

2. Please complete the following Medicaid per diem worksheet for the facility.

	COSTS		REIMBURSEMENT		MAXIMUM RATE	
Expense	Current FY 20__	First FY 20__ Project Approved	Current FY 20__	First FY 20__ Project Approved	Current FY 20__	First FY 20__ Project Approved
Direct Labor						
Fair Rental						
Management						
All Others						
Pass Through Items						
TOTAL:						

APPENDIX C (CONT.)

3. Please complete the following itemization of projected utilization and net patient revenue.

<-- FIRST FULL OPERATING YEAR 20__ -->			
PAYOR	CEC APPROVED	CEC NOT APPROVED	DIFFERENCE
MEDICAID:			
Per Diem Revenue	\$	\$	\$
Patient Days	#	#	#
Total Revenue	\$	\$	\$
MEDICARE:			
Per Diem Revenue	\$	\$	\$
Patient Days	#	#	#
Total Revenue	\$	\$	\$
COMMERCIAL:			
Per Diem Revenue	\$	\$	\$
Patient Days	#	#	#
Total Revenue	\$	\$	\$
PRIVATE PAY:			
Per Diem Revenue	\$	\$	\$
Patient Days	#	#	#
Total Revenue	\$	\$	\$
VETERANS:			
Per Diem Revenue	\$	\$	\$
Patient Days	#	#	#
Total Revenue	\$	\$	\$
OTHER: ()::			
Per Diem Revenue	\$	\$	\$
Patient Days	#	#	#
Total Revenue	\$	\$	\$
TOTAL PATIENT REVENUE:	\$	\$	\$
TOTAL PATIENT DAYS:	#	#	#

APPENDIX D

SOURCE OF FUNDS

All applicants must complete this Appendix.

I. Please provide the total expenditures necessary to implement this proposal and allocate this amount to the sources of funds categories listed below:

TOTAL PROJECT COST: \$ _____ *

<u>SOURCE OF FUNDS</u>	<u>AMOUNT</u>
a. Funded depreciation	\$ _____
b. Other restricted funds (specify) _____	_____
c. Unrestricted funds (specify) _____	_____
d. Owner's equity	_____
e. Sale of stock/other equity	_____
f. Unrestricted donations or gifts	_____
g. Restricted donations or gifts	_____
h. Government grant (specify) _____	_____
i. Other non-debt funds (specify) _____	_____
j. Sub-Total Equity Funds	_____
k. Subsidized loan (e.g. FHA etc.) _____	_____
l. Tax-exempt bonds (specify) _____	_____
m. Conventional mortgage	_____
n. Lease or rental	_____
o. Other debt funds	_____
p. Sub-Total Debt Funds	_____
q. Total Source of Funds	_____

* should equal the response for line "q"

APPENDIX E

DEBT FINANCING

All applicants proposing debt financing must complete this Appendix.

Applicants contemplating the incurrence of a financial obligation for full or partial funding of the proposal must complete and submit this appendix.

1. Please describe the proposed debt by completing the following:

- a.) type of debt contemplated _____
- b.) term (months or years) _____
- c.) principal amount borrowed _____
- d.) probable interest rate _____
- e.) points, discounts, origination fees _____
- f.) compensating balance or reserved fund _____
- g.) likely security _____
- h.) disposition of property (if a lease is revoked) _____
- i.) prepayment penalties or call features _____
- j.) front end costs (e.g. underwriting spread,
feasibility study, legal and printing
expense, points etc.) _____
- k.) debt service reserve fund _____

2. If this proposal involves refinancing of existing debt, please indicate the original principal, the current balance, the interest rate, the years remaining on the debt and a justification for the refinancing contemplated.

3. Please present a debt service schedule for the chosen method of financing, which clearly indicates the total amount borrowed and the total amount repaid per year. Of the amount repaid per year, the total dollars applied to principal and total dollars applied to interest must be shown.

Appendix F

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

All applicants must complete this Appendix.

I. Please answer the following questions by checking either 'Yes' or 'No'. If any of the questions are answered 'Yes', please list the names and addresses of individuals or corporations on an attached sheet (identify each answer with the appropriate number of the question).

- A. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant, that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX of the Social Security Act? Yes___ No___
- B. Will there be any directors, officers, agents, or managers of the applicant (or facility) who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX of the Social Security Act? Yes___ No___
- C. Are there (or will there be) any individuals employed by the applicant (or facility) in a managerial, accounting, auditing, or similar capacity who were employed by the applicant's fiscal intermediary within the past 12 months (Title XVIII providers only)? Yes___ No___
- D. Will there be any individuals (or organizations) having direct (or indirect) ownership interests, separately (or in combination), of 5 percent or more in the applicant (or facility)? (Indirect ownership interest is ownership in any entity higher in a pyramid than the applicant) Yes___ No___ (Note, if the applicant is a subsidiary of a "parent" corporation, the response is 'Yes')
- E. Will there be any individuals (or organizations) having ownership interest (equal to at least 5 percent of the facility's assets) in a mortgage or other obligation secured by the facility? Yes___ No___
- F. Will there be any individuals (or organizations) that have an ownership or control interest of 5 percent or more in a subcontractor in which the applicant (or facility) has a direct or indirect ownership interest of 5 percent or more. (Also, please identify those subcontractors.) Yes___ No___
- G. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant (or facility), who have been direct (or indirect) owners or employees of a health care facility against which sanctions (of any kind) were imposed by any governmental agency? Yes___ No___
- H. Will there be any directors, officers, agents, or managing employees of the applicant (or facility) who have been direct (or indirect) owners or employees of a health care facility against which any sanctions were imposed by any governmental agency? Yes___ No___